Anthem. BlueCross BlueShield

Enrollment and Membership Change Form

1. Tell Us About You

Current Anthem Blue Cross and Blue Shield Contract Number, if any

Last Name | First Name | M.I.

Home Address: Number and Street or P.O. Box | Apt. #

City | State | ZIP Code

Home Telephone | Work Telephone

MARITAL STATUS: ☐ Single ☐ Legally Separated ☐ Widowed ☐ Married ☐ Separated ☐ Divorced

2. New Membership

☐ NEW HIRE
☐ OPEN ENROLLMENT
☐ COBRA/C.G.S. 38a-538
DATE OF QUALIFYING EVENT ______
REASON ______ SEE INSTRUCTION SHEET
☐ NEW GROUP (ORIG ENROLLMENT)

3. Change Membership

CHANGE:
☐ ADDRESS
☐ NAME
______
☐ OTHER
REASON ______
DATE ______

TO BE COMPLETED BY EMPLOYER

Requested Effective Date ______

Firm Division No.

Health Benefit Plan

For Office Use Only

4. Your Membership Choices

	Individual	Two Person	Family
☐ Bluecare______	☐	☐	☐
☐ Century Preferred/PPO______	☐	☐	☐
☐ Dental______	☐	☐	☐
☐ HMO Blue New England	☐	☐	☐
☐ Blue Choice New England	☐	☐	☐
☐ Access Blue New England	☐	☐	☐
☐ Lumenos HSA*______	☐	☐	☐
☐ Lumenos HRA______	☐	☐	☐
☐ Lumenos HIA	☐	☐	☐
☐ Lumenos HIA Plus	☐	☐	☐

Confirm with your employer which HSA custodian was selected.

☐ BLUE VIEW VISION ______

☐ OTHER ______	☐	☐	☐

Are you or any other eligible dependent listed on this form currently confined to a hospital or other health care facility, totally disabled or physically impaired? ☐ YES ☐ NO

5. Where You Work

COMPANY NAME

ARE YOU ACTIVELY AT WORK? ☐ YES ☐ NO (IF NO) REASON ☐ SICK ☐ INJURED ☐ OTHER

ARE YOU CURRENTLY CLAIMING WORKERS' COMP. MEDICAL BENEFITS? ☐ YES ☐ NO

DO YOU WORK 30 OR MORE HOURS PER WEEK? ☐ YES ☐ NO

DATE OF FULL-TIME HIRE	DATE OF PART-TIME HIRE	DATE OF REHIRE

6. List Members To Be Added/Cancelled

SEX	NAME (FIRST/MIDDLE/LAST NAME)	Add	Cancel	Vision	Social Security Number	Date of Birth (MM/DD/YYYY)	Full-time Student Age 19 or Over (Circle Yes or No)	BELOW PLEASE INDICATE NAME OF RECOGNIZED INSTITUTION FOR FULL-TIME STUDENTS	Primary Care Physician (PCP) Name (Refer to Provider Directory or anthem.com) Check ☑ the box if you currently use this physician.
☐ M ☐ F	Self								Name / City / PCP Provider No. ☐
☐ M ☐ F	Spouse/Domestic Partner								Name / City / PCP Provider No. ☐
DEPENDENTS: Children up to age 26 may be eligible. Please indicate if a child is a full-time student and circle disabled dependents.									
☐ M ☐ F	Dependent						Y N		Name / City / PCP Provider No. ☐
☐ M ☐ F	Dependent						Y N		Name / City / PCP Provider No. ☐
☐ M ☐ F	Dependent						Y N		Name / City / PCP Provider No. ☐

7. Tell Us About Your Other Insurance

Do you or any other member of your family have any other medical, dental, or Anthem Blue Cross and Blue Shield coverage? ☐ YES ☐ NO

If yes, please fill in the information below. ☐ Self ☐ Spouse/Domestic Partner ☐ Children

Name of Other Insurance Company	Name of Subscriber (Policyholder)	Policy or ID No.	Reason for Termination	First and Last Date of Coverage

8. Medicare/Medicaid

Do you or any covered member have Medicare/Medicaid coverage? ☐ YES ☐ NO

Have you or any covered member applied for Medicare/Medicaid disability? ☐ YES ☐ NO

Name (Self) | Are you actively at work? ☐ YES ☐ NO | Retirement Date

Medicare No. | Effective Dates: Medicare A | Medicare B | Medicare D

Name (Dependent) | Is this person actively at work? ☐ YES ☐ NO | Retirement Date

Medicare No. | Effective Dates: Medicare A | Medicare B | Medicare D

For insurance entities, the term "medical loss ratio" refers to the ratio of incurred claims to earned premium for a prior calendar year. The MLR is calculated for managed care (HMO) and PPO/Indemnity plans, one for state law purposes and the other as determined under federal law. For 2011, Anthem's Medical Loss Ratio for state law purposes was 81.0% for HMO plans and 81.4% for PPO/Indemnity plans. For 2011, Anthem's MLR for federal law purposes was 86.3% for small group plans and 88.3% for large group plans. I understand that intentionally false and/or intentionally incomplete responses or statements may in result rescission of coverage and/or non-payment of claims for myself or my eligible dependents. I understand a copy of this application is provided to me as part of my Subscriber Agreement or health benefit plan document as applicable and is incorporated by reference therein. I certify that my statements in this form are true and complete to the best of my knowledge and belief.

9. Employee Signature

Date

6. *List Members To Be Added/Cancelled*

DEPENDENTS: Children up to age 26 may be eligible. Please indicate if a child is a full-time student and circle disabled dependents.

SEX	NAME (FIRST/MIDDLE/LAST NAME)	Add	Cancel	Vision	Social Security Number	Date of Birth (MM/DD/YYYY)	Full-time Student Age 19 or Over (Circle Yes or No)	BELOW PLEASE INDICATE NAME OF RECOGNIZED INSTITUTION FOR FULL-TIME STUDENTS	Primary Care Physician (PCP) Name (Refer to Provider Directory or anthem.com) Check ☑ the box if you currently use this physician.
☐ M ☐ F	Dependent						Y N		Name PCP Provider No. ☐ City
☐ M ☐ F	Dependent						Y N		Name PCP Provider No. ☐ City
☐ M ☐ F	Dependent						Y N		Name PCP Provider No. ☐ City
☐ M ☐ F	Dependent						Y N		Name PCP Provider No. ☐ City
☐ M ☐ F	Dependent						Y N		Name PCP Provider No. ☐ City
☐ M ☐ F	Dependent						Y N		Name PCP Provider No. ☐ City
☐ M ☐ F	Dependent						Y N		Name PCP Provider No. ☐ City

8. *Medicare/Medicaid*

Name (Dependent)	Is this person actively at work? ☐ YES ☐ NO	Retirement Date	Name (Dependent)	Is this person actively at work? ☐ YES ☐ NO	Retirement Date
Medicare No.	Effective Dates: Medicare A / Medicare B / Medicare D		Medicare No.	Effective Dates: Medicare A / Medicare B / Medicare D	
Name (Dependent)	Is this person actively at work? ☐ YES ☐ NO	Retirement Date	Name (Dependent)	Is this person actively at work? ☐ YES ☐ NO	Retirement Date
Medicare No.	Effective Dates: Medicare A / Medicare B / Medicare D		Medicare No.	Effective Dates: Medicare A / Medicare B / Medicare D	
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Medicare No.	Effective Dates: Medicare A / Medicare B / Medicare D		Medicare No.	Effective Dates: Medicare A / Medicare B / Medicare D	

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